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103D CONGRESS
1ST SESSION

H. R. 1976

To guarantee access to affordable health care coverage, to provide for equality with respect to the provision of service in rural areas, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 5, 1993

Mr. THOMAS of Wyoming introduced the following bill; which was referred jointly to the Committees on Ways and Means, Energy and Commerce, the Judiciary, and Education and Labor

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A BILL

To guarantee access to affordable health care coverage, to provide for equality with respect to the provision of service in rural areas, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Comprehensive Health and Rural Equality Act of 1993''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—GUARANTEED ACCESS TO AFFORDABLE HEALTH CARE COVERAGE

SEC. 101. REQUIREMENT OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Each eligible individual who does not establish (in a manner specified by the Secretary) coverage under a health insurance program (as defined in section 105(2)) shall—

(1) register with the Secretary under section 102, and

(2) be enrolled under a MedEquality plan in accordance with this title.

(b) ENFORCEMENT THROUGH INFORMATION CONCERNING HEALTH COVERAGE SHOWN ON TAX RE-

TURN.—Section 6012 of the Internal Revenue Code of 1986 is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

''(e) HEALTH CARE COVERAGE.—Every person required to file a return under this section for the taxable year shall include on such return a statement declaring whether or not the taxpayer and dependents of the taxpayer are covered under an accident or health plan as of the time such return is filed.''

SEC. 102. REGISTRATION OF ELIGIBLE UNINSURED INDIVIDUALS.

(a) BY MAIL.—Each eligible individual who is not insured under a MedEquality plan or other health care plan shall register under this title, either as an individual or as a member of a family, by mailing a registration form to the Secretary.

(b) AVAILABILITY OF FORMS.—The Secretary shall make registration forms readily available at post offices and other suitable locations.

SEC. 103. CREDIT CERTIFICATES.

(a) CREDIT CERTIFICATES.—

(1) IN GENERAL.—Each individual, in a State with an agreement described in subsection (d)(2), determined to be a credit eligible individual (as de-

fined in subsection (b)) shall receive a credit certificate the value of which may be applied towards purchase of a MedEquality plan through an employer or an insurer.

(2) VALUE OF CERTIFICATE.—

(A) SCALED TO INCOME.—The value of a credit certificate for an individual shall be scaled according to the income of the individual, in a manner specified by the Secretary so that—

(i) for individuals and families with income below the poverty level, the value equals the maximum value, and

(ii) for individuals and families with income more than 150 percent of the poverty level, there is no value to the credit certificate.

(B) LIMIT TO LOWEST PREMIUM CHARGED.—The value of the credit certificate under this section shall not exceed the cost of coverage under the least expensive MedEquality plan available for the type of coverage under which the individual is enrolled.

(3) APPLICATION OF CREDIT CERTIFICATE.—In accordance with regulations of the Secretary, upon

presentation of a credit certificate of an individual to a MedEquality plan, the plan shall reduce the value of the premium otherwise imposed and shall transmit to the State electronically such information as may be required in order for the State to provide for payment to the plan (in accordance with subsection (c)(1)(C)).

(b) CREDIT ELIGIBLE INDIVIDUAL DEFINED.—In this title, the term ''credit eligible individual'' means a eligible individual—

(1) whose income (as determined under section 1612 of the Social Security Act for purposes of the supplemental security income program) does not exceed 150 percent of the poverty level; and

(2) whose resources (as determined under section 1613 of such Act for purposes of the supplemental security income program) do not exceed the maximum amount of resources that an individual may have and obtain benefits under that program.

(c) ELIGIBILITY DETERMINATION.—

(1) STATE RESPONSIBILITY.—States are responsible—

(A) for determining if individuals are credit eligible individuals;

(B) in the case of credit eligible individuals, for determining the value of the credit certificate and for the issues of certificates to such individuals; and

(C) for making payment to MedEquality plans for the value of certificates presented to them.

(2) APPLICATION.—

(A) IN GENERAL.—States shall provide that individuals seeking a determination that they are credit eligible individuals may apply for, and obtain, such a determination (and if found eligible, for a credit certificate under subsection (a)) in conjunction with—

(i) applying for public welfare assistance (including assistance under title IV, or supplemental security income benefits under title XVI, of the Social Security Act), and

(ii) receiving medical services at a hospital emergency room.

(B) PERIODIC REAPPLICATIONS.—Individuals who are determined to be credit eligible individuals are required to reapply for such determination (and the determination of the amount

of the credit certificate) not less often than once every 6 months.

(3) USE OF SOCIAL SECURITY ADMINISTRATION.—At the request of a State, the Secretary may enter into an agreement with a State under which eligibility determinations under this section are conducted by the Social Security Administration on behalf of the State.

(d) PAYMENT TO STATES.—

(1) IN GENERAL.—From the amounts in the Treasury not otherwise appropriated, the Secretary shall provide for payments to States with an agreement in effect under paragraph (2) (on a quarterly basis in the same manner as payments are made to States under section 1903(d) of the Social Security Act) of amounts equal to the sum of—

(A) the Federal medical assistance percentage (as defined in section 1905(a)(2) of such Act) amounts paid by the States for credit certificates issued under subsection (c), and

(B) 60 percent of the reasonable administrative expenses of the State in administering the certificate program under this title.

(2) AGREEMENTS.—An agreement under this paragraph is an agreement between the Secretary and a State which provides—

(A) for the State—

(i) to carry out this title in the State (including implementing section 104(b)), and

(ii) to comply with the applicable requirements of section 502 (relating to comprehensive plans for medically underserved rural populations); and

(B) for the Secretary to make payments to the State under paragraph (1).

(3) RELATION TO MEDICAID PROGRAM.—

(A) DUPLICATION.—Notwithstanding any other provision of law, such a State plan is not required to provide for benefits for services under such State plan to the extent the individual is entitled to benefits for such services under a MedEquality plan.

(B) MEDICAID AS SECONDARY PAYOR.—State plans for medical assistance under title XIX of the Social Security Act shall, under section 1902(a)(25) of such Act, not make payment for services to the extent that payment

may be made for such services under a MedEquality plan.

(e) NOTICE.—Whenever a credit certificate is issued under this section, the issuer shall notify the Commissioner of Internal Revenue concerning such issuance.

SEC. 104. REQUIREMENT FOR OFFERING OF MEDEQUALITY PLANS.

(a) IN GENERAL.—Each licensed insurance carrier in a State shall make available a MedEquality plan to all individuals residing in the State.

(b) ENFORCEMENT.—If a carrier in a State fails to comply with development of a MedEquality plan, the Insurance Commissioner of the State shall revoke the carrier's license to offer health insurance in the State.

SEC. 105. DEFINITIONS.

In this title:

(1) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means an individual who (A) is a citizen or national of the United States, an alien lawfully admitted for permanent residence, or an alien otherwise permanently residing in the United States under color of law and (B) is residing in the United States.

(2) HEALTH INSURANCE PROGRAM.—The term ''health insurance program'' means any private or

public program, other than a MedEquality plan, that provides for benefits (through insurance or otherwise) that are not less than the benefits provided under a MedEquality plan, and includes the medicare and medicaid programs (under titles XVIII and XIX of the Social Security Act), the Federal employees health insurance program (under chapter 89 of title 5, United States Code), the program for the provision of medical and dental benefits under chapter 55 of title 10, United States Code, and the program for the provision of hospital care and medical services by the Department of Veterans Affairs under chapter 17 of title 38, United States Code.

(3) MEDEQUALITY PLAN.—The term ''MedEquality plan'' has the meaning given such term in section 203(b).

(4) POVERTY LEVEL.—The term ''poverty level'' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(6) STATE.—The term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

TITLE II—SMALL EMPLOYER INSURANCE REFORM

SEC. 201. ESTABLISHMENT AND ENFORCEMENT OF STANDARDS FOR SMALL EMPLOYER HEALTH INSURANCE PLANS.

(a) ESTABLISHMENT OF GENERAL STANDARDS.—

(1) ROLE OF NAIC.—The Secretary of Health and Human Services shall request the National Association of Insurance Commissioners to develop, within 1 year after the date of the enactment of this Act, model regulations that specify standards with respect to each of the following:

(A) The requirement, under section 203(a), that small employer carriers offer MedEquality plans.

(B) The basic benefits to be included in MedEquality plans under section 203(b).

(C) The requirements of guaranteed issue of MedEquality plans under section 203(c).

(D) The requirements of sections 204 and 205(b).

(E) The requirements of subsections (a) and (c) of section 205.

If the NAIC develops such regulations specifying such standards within such period, the Secretary shall review such standards to determine if they meet such requirements. Such review shall be completed within 6 months after the date the regulations are developed. Unless the Secretary determines within such period that the standards do not meet the requirements, such standards shall serve as the standards under this section.

(2) CONTINGENCY.—If the NAIC does not develop such model regulations within such period or the Secretary determines that such regulations do not meet the requirements described in paragraph (1), the Secretary shall inform the NAIC of the specific deficiencies and request the NAIC to develop such model regulations in conformity with paragraph (1).

(3) EFFECTIVE DATE.—The standards provided under this subsection—

(A) shall apply to small employer health benefit plans offered in a State on or after the date the standards are implemented in the State under subsection (b)(1), and

(B) with respect to the requirements referred to in paragraph (1)(D), shall apply to small employer health benefit plans renewed on or after 3 years after the date such standards are implemented in the State under subsection (b)(1).

(b) APPLICATION OF STANDARDS THROUGH STATES.—

(1) APPLICATION OF ALL STANDARDS TO NEW PLANS.—

(A) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in subparagraph (B), a report on the implementation and enforcement of the standards established under subsection (a) with respect to small employer health benefit plans offered not later than such deadline.

(B) DEADLINE FOR REPORT.—

(i) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to clause (ii), the deadline under this subparagraph is 1 year after the date standards are established under subsection (a).

(ii) EXCEPTION FOR LEGISLATION.—In the case of a State which the Secretary

identifies, in consultation with the NAIC, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for carriers and health benefit plans offered to small employers to meet the standards established under subsection (a), but

(II) having a legislature which is not scheduled to meet in 1994 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1994. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(2) APPLICATION OF CONSUMER PROTECTION TO ALL PLANS.—Each State shall submit to the Secretary, by not later than 4 years after the date

standards are established under subsection (a), a report on the implementation and enforcement of the standards established under subparagraphs (D) and (E) subsection (a)(1) with respect to small employer health benefit plans renewed not later than 4 years after the date such standards were established.

(3) MORE STRINGENT STATE STANDARDS PERMITTED.—A State may implement standards that are more stringent than the standards established under subsection (a).

(4) ENFORCEMENT.—If the Secretary determines that a State has failed to submit a report by the deadline under paragraph (1) or (2) or finds that the State no longer is carrying out its responsibility under the respective paragraph, the Secretary shall notify the State and provide the State a period of 30 days in which to submit such report or to carry out its responsibilities under the respective paragraph. If, after such 30-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of the standards established under subsection (a) in the State as the Secretary determines to be appropriate. Such standards shall apply to health benefit plans

offered or renewed on or after 3 months after the applicable deadlines established under subparagraphs (A) through (C) of subsection (a)(3).

SEC. 202. PREEMPTION OF STATE BENEFITS MANDATES FOR PLANS THAT MEET CONSUMER PROTECTION STANDARDS.

(a) FINDING.—Congress finds that health benefit plans offered with respect to small employers affect interstate commerce.

(b) PREEMPTION.—In the case of a small employer health benefit plan that meets the standards with respect to the requirements referred to in subparagraphs (D) and (E) of section 201(a)(1), no provision of State law shall apply that requires the offering, as part of the health benefit plan with respect to such an employer, of any services, category of care, or services of any class or type of provider.

SEC. 203. REQUIREMENT FOR OFFERING OF BASIC, LOW COST PLAN (MEDEQUALITY PLAN).

(a) IN GENERAL.—Each small employer carrier which makes available in a State any small employer health benefit plan shall make available to each small employer in the State a MedEquality plan (as defined in subsection (b)).

(b) MEDEQUALITY PLAN DEFINED.—

(1) IN GENERAL.—In this title, except as provided in paragraph (2), the term ''MedEquality plan'' means a health benefits plan that—

(A) is designed to provide only basic hospital, medical, surgical, preventive, and diagnostic benefits, specified under standards under section 201(a)(1)(B), so as to make it affordable to small employers;

(B) includes cost-sharing that provides an appropriate incentive to avoid unnecessary care while avoiding excessive cost-sharing by individuals with catastrophic illnesses;

(C) is guaranteed issue (as described in subsection (c));

(D) meets the standards established under subparagraphs (D) and (E) of section 201(a)(1) (relating to the requirements of sections 204 and 205); and

(E) provides for cost-containment in accordance with the model made applicable under subsection (d) in the State in which the plan is issued.

(2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—With respect to a carrier that is a Federally-qualified health maintenance or-

ganization (as defined in section 1301(a) of the Public Health Service Act), the term ''MedEquality plan'' means a plan of the type described in paragraph (1) but with benefits that are consistent with the requirements for the plans of such an organization under title XIII of such Act. With respect to a carrier that is not such a Federally-qualified health maintenance organization but which is recognized under State law as a health maintenance organization, the term ''MedEquality plan'' means a plan of the type described in paragraph (1) but with benefits that are consistent with the requirements of State law for the plans of such an organization.

(3) REVIEW OF MINIMUM BENEFIT STANDARDS.—The NAIC is requested to periodically review the standards for minimum benefits described in paragraph (1)(A). The NAIC is requested to submit to the Secretary and the Congress its recommendations on changes that should be made in such standards.

(c) GUARANTEED ISSUE FOR MEDEQUALITY PLANS.—

(1) IN GENERAL.—Each MedEquality plan in a State—

(A) subject to paragraph (2), must accept every small employer in the State that applies for coverage under the plan;

(B) subject to paragraphs (2) and (3), must accept for enrollment every individual who is a full-time employee (or, in the case of family enrollment with respect to such an employee, the employee's spouse and the employee's dependents who are under 19 years of age or who are full-time students and under 21 years of age) who applies for enrollment on a timely basis; and

(C) subject to paragraphs (2) and (3), may not place any restriction on the eligibility of an individual to enroll, so long as such an individual is a full-time employee or the employee's spouse or dependent described in subparagraph (B).

(2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of a MedEquality plan offered by a health maintenance organization, the plan shall—

(A) limit the employers that may apply for coverage to those with eligible individuals residing in the service area of the plan,

(B) limit the individuals who may be enrolled under the plan to those who reside in the service area of the plan, and

(C) within the service area of the plan, deny coverage to such employers if the plan demonstrates that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this subparagraph uniformly to all employers without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

(3) EXCEPTION FOR CERTAIN LATE ENROLLEES.—

(A) IN GENERAL.—Except as provided in this paragraph, paragraph (1)(B) shall not apply to an eligible employee or dependent who fails to enroll in a health benefit plan during an initial enrollment period, if such period is at least 30 days long.

(B) EXCEPTION FOR THOSE WITH PREVIOUS EMPLOYER COVERAGE.—Subparagraph (A) shall not apply to an individual who—

(i) was covered under another employer health benefit plan at the time of the individual's initial enrollment period,

(ii) stated at the time of initial enrollment period that coverage under another employer health benefit plan was the reason for declining enrollment,

(iii) lost coverage under another employer health benefit plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce, and

(iv) requests enrollment within 30 days after termination of coverage under another employer health benefit plan.

(C) EXCEPTION FOR OPEN ENROLLMENT.—Subparagraph (A) shall not apply to an individual who—

(i) is employed by an employer which offers multiple health benefit plans, and

(ii) elects a different plan during an open enrollment period.

(D) EXCEPTION FOR COURT ORDERS.—Subparagraph (A) shall not apply to a spouse or minor child if a court has ordered coverage be provided for the spouse or child under a covered employee's health benefit plan and request for such coverage is made within 30 days after issuance of such court order.

(d) COST CONTAINMENT STANDARDS.—

(1) DEVELOPMENT OF MODELS.—

(A) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 1 year after the date of the enactment of this Act, models for cost-containment features in MedEquality plans. Such models shall include a managed care plan (described in paragraph (3)) and any combination of such models the NAIC finds appropriate. If the NAIC develops such models within such period, the Secretary shall review such models to determine if they provide for effective cost-containment. Such review shall be completed within 6 months after the date the models are developed. Unless the Secretary determines within such period that such a model does not provide effective cost-containment,

such remaining models shall serve as the models under this subsection.

(B) CONTINGENCY.—If the NAIC does not develop such models within such period or the Secretary determines that all such models do not provide for effective cost-containment, the Secretary shall inform the NAIC of the specific deficiencies and request the NAIC to develop such models in conformity with paragraph (1).

(2) SELECTION OF COST-CONTAINMENT MODEL BY STATE.—By not later than 2 years after the date of the enactment of this Act, each State shall specify the cost-containment model (developed under paragraph (1)) that will be applied under subsection (a) to MedEquality plans issued in the State.

(3) MANAGED CARE PLAN DEFINED.—For purposes of paragraph (1), the term ''managed care plan'' includes (but is not limited to) any plan that—

(A) arranges with selected providers for the furnishing of health care services,

(B) provides explicit standards for the selection of such providers,

(C) has formal programs for ongoing quality assurance and utilization review, and

(D) provides significant financial incentives for beneficiaries to use providers and procedures associated with the plan.

(d) ROLE OF STATE INSURANCE COMMISSIONER.—The commissioner or superintendent of insurance of each State shall be responsible for determining that the premium charged for each MedEquality plan is reasonable and not excessive in relation to the benefits.

SEC. 204. REQUIREMENTS RELATING TO INITIAL WRITING OF POLICIES.

(a) LIMITATIONS ON TREATMENT OF PRE-EXISTING CONDITIONS.—

(1) IN GENERAL.—A carrier may not impose (or require an employer to impose through a waiting period for coverage under a health benefit policy or similar requirement) a limitation or exclusion of benefits under a small employer health benefit plan relating to treatment of a condition based on the fact that the condition preexisted the effectiveness of the policy if—

(A) the condition relates to a condition that did not exist within 6 months before the date of coverage under the plan, or

(B) the limitation or exclusion extends over more than 12 months after the date of coverage under the plan.

(2) PREVIOUS SATISFACTION OF PREEXISTING CONDITION REQUIREMENT.—

(A) IN GENERAL.—In addition, each carrier shall waive any period applicable to a preexisting condition for similar benefits with respect to an individual to the extent that the individual was covered for the condition under a small employer health benefit plan that was in effect before the date of the enrollment under the carrier's plan.

(B) CONTINUOUS COVERAGE REQUIRED.—Subparagraph (A) shall no longer apply if there is a continuous period of more than 60 days on which the individual was not covered under an employer health benefit plan.

(b) LIMITS ON PREMIUMS.—

(1) LIMIT ON VARIATION OF INDEX RATES BETWEEN BLOCKS OF BUSINESS.—

(A) IN GENERAL.—As a standard under section 202, the index rate for a rating period for any block of business of a small employer carrier may not exceed the index rate for any

other block of business by more than 20 percent.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply to a block of business if—

(i) the block is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the block of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status,

(ii) the carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the block of business, and

(iii) the block of business is currently available for purchase.

(2) LIMIT ON VARIATION OF PREMIUM RATES WITHIN A BLOCK OF BUSINESS.—For a block of business of a small employer carrier, as a standard under section 202 the premium rates charged during a rating period to small employers with similar demographic or other relevant characteristics (not relating to claims experience, health status, or dura-

tion of coverage) for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that block of business, shall not vary from the index rate by more than 25 percent of the index rate.

(3) LIMIT ON PERMISSIBLE RATE VARIATIONS.—Subject to paragraphs (1) and (2), as a standard under section 202, a carrier may establish rate variations based on factors such as geography, demography, and industry and plan design.

(4) LIMIT ON TRANSFER OF EMPLOYERS AMONG BLOCKS OF BUSINESS.—As a standard under section 202, a small employer carrier may not involuntarily transfer a small employer into or out of a block of business. A small employer carrier may not offer to transfer a small employer into or out of a block of business unless such offer is made to transfer all small employers in the block of business without regard to demographic characteristics, claim experience, health status, or duration since issue.

(5) DEFINITIONS.—In this subsection:

(A) BASE PREMIUM RATE.—The term ''base premium rate'' means, for each block of business for each rating period, the lowest premium rate charged or which could have been

charged under a rating system for that block of business by the small employer carrier to small employers with similar demographic or other relevant characteristics (not relating to claims experience, health status, or duration of coverage) for health benefit plans with the same or similar coverage.

(B) BLOCK OF BUSINESS.—The term ''block of business'' means, with respect to a carrier, all (or a distinct group of) small employers as shown on the records of the carrier.

(C) RULES FOR ESTABLISHING BLOCKS OF BUSINESS.—For purposes of subparagraph (B)—

(i) a carrier may establish, subject to clause (ii), a distinct group of small employers on the basis that the applicable health benefit plans either—

(I) are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groups of small employers for the carrier,

(II) have been acquired from another carrier as a distinct group, or

(III) are provided through an association with membership of not less than 100 small employers which has been formed for purposes other than obtaining insurance;

(ii) a carrier may not establish more than 2 groupings under each block of business because the carrier uses managed-care techniques which are expected to produce substantial variation in health care costs; and

(iii) notwithstanding clauses (i) and (ii), a Commissioner of Insurance of a State may, upon application, approve additional distinct groups upon a finding that such approval would enhance the efficiency and fairness of the small employer marketplace.

(D) INDEX RATE.—The term ''index rate'' means, with respect to a block of business, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate for the block.

(c) FULL DISCLOSURE OF RATING PRACTICES.—At the time a carrier offers a health benefit plan to a small employer, the carrier shall fully disclose to the employer rating practices for small employer health benefit plans, including rating practices for different industries, populations, and benefit designs.

(d) ACTUARIAL CERTIFICATION.—Each carrier shall file annually with the State commissioner of insurance a written statement by a member of the American Academy of Actuaries (or other individual acceptable to the commissioner) that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the carrier and methods used by the carrier in establishing premium rates for applicable small employer health benefit plans—

(1) the carrier is in compliance with the applicable provisions of this section, and

(2) the rating methods are actuarially sound.

Each carrier shall retain a copy of such statement for examination at its principal place of business.

(e) REGISTRATION AND REPORTING.—Each carrier that issues any small employer health benefit plan in a State shall be registered or licensed with the State commissioner of insurance and shall comply with any report-

ing requirements of the commissioner relating to such a plan.

(f) USE OF MINIMUM PARTICIPATION REQUIREMENT.—A carrier may condition issuance, or renewal, of a health benefit plan to a small employer on the enrollment of a minimum number (or percentage) of its full-time employees, in accordance with standards established to carry out this section. Such standards shall require that any such conditions be imposed uniformly on employers of the same size.

SEC. 205. REQUIREMENTS RELATING TO RENEWAL.

(a) RENEWABILITY.—A carrier may not cancel a small employer health benefit plan or deny renewal of coverage under such a plan other than—

(1) for nonpayment of premiums,

(2) for fraud or other misrepresentation by the insured,

(3) for noncompliance with plan provisions,

(4) for failure to maintain (in accordance with standards established under section 204(f)) the number of enrollees under the plan at the number (or percentage) required under the plan,

(5) for misuse of a provider network provision, or

(6) because the carrier is ceasing to provide any small employer health benefit plan in a State, or, in the case of a health maintenance organization, in a geographic area.

(b) LIMITATION ON PREMIUM INCREASES.—A carrier may not provide for an increase in the premium charged a small employer for a small employer health benefit plan in a percentage greater than such percentage as shall be specified in standards referred to in section 201(a)(1)(E). Such standards shall take into account increases in premiums charged for new coverage of small employers under the plan.

(c) LIMITATION ON MARKET REENTRY.—If a carrier terminates the offering of health benefit plans to small employers in an area, the carrier may not offer such a health benefit plan to any small employer in the area until 5 years have elapsed since the date of the termination.

SEC. 206. ESTABLISHMENT OF REINSURANCE MECHANISMS FOR HIGH RISK INDIVIDUALS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 1 year after the date of the enactment of this Act, models for reinsurance mechanisms (each in this section referred to as the ''reinsurance mechanism'') for individuals and

small employers who are enrolled under a small employer health benefit plan that meets the standards with respect to the requirements referred to in subparagraphs (D) and (E) of section 201(a)(1) and for whom a carrier is at risk of incurring high costs under the plan. Such models shall include models based on each of the following:

(A) A voluntary prospective reinsurance option.

(B) A retrospective reinsurance option.

(C) An allocation option.

(D) A pooled employee option.

(E) A designated carrier option.

(F) A mandatory reinsurance option.

If the NAIC develops such models within such period, the Secretary shall review such models to determine if they provide for an effective reinsurance mechanism. Such review shall be completed within 6 months after the date the models are developed. Unless the Secretary determines within such period that such a model is not an effective reinsurance mechanism, such remaining models shall serve as the models under this section.

(2) CONTINGENCY.—If the NAIC does not develop such models within such period or the Sec-

retary determines that all such models do not provide for an effective reinsurance mechanism, the Secretary shall inform the NAIC of the specific deficiencies and request the NAIC to develop such models in conformity with paragraph (1).

(b) REQUIREMENT OF IMPLEMENTATION OF REINSURANCE MECHANISMS.—

(1) IN GENERAL.—By not later than 2 years after the date of the enactment of this Act, each State shall establish one or more reinsurance mechanisms by not later than the deadline specified in section 201(b)(1)(B) of this Act.

(2) DEFAULT.—If the Secretary determines that a State has failed to establish any reinsurance mechanism under paragraph (1), the Secretary shall establish one or more such mechanisms with respect to that State. The authority provided under the previous sentence shall expire upon the Secretary's determination that the State has provided, by law, for establishment of a reinsurance mechanism that meets the requirement of paragraph (1).

(c) CONSTRUCTION.—Nothing in this section shall be construed as to prohibit reinsurance arrangements, whether on a State or regional basis, not required under this section.

SEC. 207. REGISTRATION OF ALL HEALTH BENEFIT PLANS REQUIRED.

Notwithstanding any other provision of law, each State commissioner or superintendent of insurance may, under State law, require each employer health benefit plan (including a self-insured plan) to be registered with such official, if the plan is not otherwise required to be registered or licensed with the official under section 204(e), and to provide the official with such information on the plan as may be necessary to carry out section 206.

SEC. 208. DEFINITIONS.

In this subtitle:

(1)(A) The term ''carrier'' means any entity which provides health insurance or health benefits in a State, and includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement or employee benefits plan (as defined under the Employee Retirement Income Security Act of 1974), or any other entity providing a plan of health insurance subject to State insurance regulation.

(B) The term ''small employer carrier'' means a carrier with respect to the issuance of a small employer health benefit plan.

(2) The term ''health benefit plan'' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, but does not include—

(A) accident-only, credit, dental, or disability income insurance,

(B) coverage issued as a supplement to liability insurance,

(C) worker's compensation or similar insurance, or

(D) automobile medical-payment insurance.

(3) The term ''NAIC'' means the National Association of Insurance Commissioners.

(4) The term ''Secretary'' means the Secretary of Health and Human Services.

(5)(A) The term ''small employer'' means an entity actively engaged in business which, on at least 50 percent of its working days during the preceding year, employed at least 3, but fewer than 50, full-time employees. For purposes of determining if an employer is a small employer, rules similar to the rules of subsections (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

(B) The term ''full-time employee'' means, with respect to an employer, an individual who normally is employed for at least 30 hours per week by the employer.

(6) The term ''small employer health benefit plan'' means a health benefit plan which provides coverage to one or more full-time employees of a small employer.

(7) The term ''State'' means the 50 States, the District of Columbia, and Puerto Rico.

(8) The term ''State commissioner of insurance'' includes a State superintendent of insurance.

SEC. 209. PREEMPTION FROM INSURANCE MANDATES FOR QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.

(a) QUALIFIED SMALL EMPLOYER PURCHASING GROUP DEFINED.—For purposes of this section, an association is a qualified small employer purchasing group if—

(1) the association submits an application to the Secretary of Health and Human Services at such time and in such form as the Secretary may require; and

(2) on the basis of information contained in the application and any other information the Secretary may require, the Secretary determines that—

(A) the association is administered solely under the authority and control of its member employers,

(B) the association's membership consists solely of employers with not more than 100 employees (except that an employer member of the group may retain its membership in the group if, after the Secretary determines that the association meets the requirements of this paragraph, the number of employees of the employer member increases to more than 100),

(C) with respect to each State in which its members are located, the association consists of not fewer than 100 employers, and

(D) at the time the association submits its application, the health benefit plans with respect to the employer members of the association are in compliance with applicable State laws relating to health benefit plans.

(b) PREEMPTION FROM INSURANCE MANDATES.—

(1) FINDING.—Congress finds that employer purchasing groups organized for the purpose of obtaining health insurance for employer members affect interstate commerce.

(2) PREEMPTION OF STATE MANDATES.—In the case of a qualified small employer purchasing group described in subsection (a), no provision of State law shall apply that requires the offering, as part of the health benefit plan with respect to an employer member of such a group, of any services, category of care, or services of any class or type of provider.

(3) PREEMPTION OF TAXES ON PREMIUMS.—In the case of a qualified small employer purchasing group described in subsection (a), no provision of State or local law shall apply that requires a provider of insurance to pay a tax on premiums received from employer members of the group under a health benefit plan obtained by the group from the insurer for its employer members.

(4) PREEMPTION OF PROVISIONS RELATING TO MANAGED CARE.—In the case of a qualified small employer purchasing group described in subsection (a), the following provisions of State law are preempted and may not be enforced against the health benefit plan with respect to an employer member of such a group:

(A) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a carrier to nego-

tiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(B) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a health benefit plan may require a beneficiary to pay when a nonplan provider is used on a nonemergency basis.

(C) RESTRICTIONS ON UTILIZATION REVIEW METHODS.—(i) Any law that—

(I) prohibits utilization review of any or all treatments and conditions;

(II) requires that such review be made by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered;

(III) requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews;

(IV) requires payments to providers for the expenses of responding to utilization review requests; or

(V) imposes liability for delays in performing such review.

(ii) Nothing in clause (i)(II) shall be construed as prohibiting a State from requiring that utilization review be conducted by a licensed health care professional, or requiring that any appeal from such a review be made by a licensed physician or by a licensed physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered.

(c) EFFECTIVE DATE.—This section shall take effect 60 days after the date of the enactment of this Act.

SEC. 210. EQUALIZATION OF TAX BENEFITS FOR SELF-EMPLOYED PERSONS.

(a) INCREASE IN DEDUCTION.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended—

(1) by striking ''25 percent'' and inserting ''the applicable percentage (determined in accordance with the following table)'',

(2) by striking the period at the end and inserting a colon, and

(3) by adding at the end thereof the following table:

''In the case of taxable years beginning in:	**The applicable percentage is:**
1994	25
1995 or 1996	50
1997 or thereafter	100.''

(b) DEDUCTION MADE PERMANENT.—Subsection (l) of section 162 of such Code is amended by striking paragraph (6).

(c) DEDUCTION LIMITED TO MEDEQUALITY PLANS OR EQUIVALENT PLANS.—Subsection (l) of section 162 of such Code is amended by adding at the end thereof the following new paragraph:

''(6) DEDUCTION LIMITED TO MEDEQUALITY PLANS OR EQUIVALENT PLANS.—No deduction shall be allowed under paragraph (1) for insurance which is not a MedEquality plan (within the meaning of section 203(b) of the Comprehensive Health and Rural Equality Act of 1993 or an equivalent plan (as defined by the Secretary).''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

SEC. 211. MANAGED CARE RIGHTS.

(a) PREEMPTION OF STATE LAW PROVISIONS.—The following provisions of State law are preempted and may not be enforced:

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a carrier to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a health benefit plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.

(3) RESTRICTIONS ON UTILIZATION REVIEW METHODS.—Any law that—

(A) prohibits utilization review of any or all treatments and conditions,

(B) requires that such review be made (i) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or (ii) by a physician in

any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered,

(C) requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews,

(D) requires payments to providers for the expenses of responding to utilization review requests, or

(E) imposes liability for delays in performing such review.

Nothing in subparagraph (B) shall be construed as prohibiting a State from (i) requiring that utilization review be conducted by a licensed health care professional or (ii) requiring that any appeal from such a review be made by a licensed physician or by a licensed physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered.

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General shall conduct a study of the benefits and cost effec-

tiveness of the use of managed care in the delivery of health services.

(2) REPORT.—By not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) and shall include in the report such recommendations as may be appropriate.

TITLE III—HEALTH CARE COST CONTAINMENT

Subtitle A—Denial of Certain Tax Deductions and Exclusion for Excess Benefits

SEC. 301. DENIAL OF EMPLOYER TAX DEDUCTION FOR PROVIDING HEALTH CARE COVERAGE IN EXCESS OF MINIMUM BENEFITS; DENIAL OF EMPLOYEE EXCLUSION FOR SUCH EXCESS COVERAGE.

(a) DENIAL OF DEDUCTION.—Section 162 of the Internal Revenue Code of 1986 (relating to trade or business expenses) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following new subsection:

''(m) EXPENSES FOR PROVIDING HEALTH CARE IN EXCESS OF MINIMUM BENEFITS.—No deduction shall be

allowed under this chapter for expenses incurred to provide health care for any employee of the taxpayer (or any beneficiary of such employee) to the extent such expenses are attributable to benefits that are not within the basic benefits included in MedEquality plans under section 203(b) of the Comprehensive Health and Rural Equality Act of 1993.''

(b) DENIAL OF EXCLUSION.—The text of section 106 of such Code is amended to read as follows:

''(a) IN GENERAL.—Gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) NO EXCLUSION FOR HEALTH CARE COVERAGE IN EXCESS OF MINIMUM BENEFITS.—Subsection (a) shall not apply to the extent coverage is provided for benefits that are not within the basic benefits included in MedEquality plans under section 203(b) of the Comprehensive Health and Rural Equality Act of 1993.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning on or after the first day of the second calendar year beginning after the date of the enactment of this Act, but shall not apply to taxable years beginning before the date the basic benefits, to be included in MedEquality plans under sec-

tion 203(b) of this Act, have become effective under section 203(a)(3) of this Act.

Subtitle B—Medical Malpractice Reform

PART 1—GENERAL PROVISIONS

SEC. 311. FEDERAL REFORM OF MEDICAL MALPRACTICE LIABILITY ACTIONS.

(a) CONGRESSIONAL FINDINGS.—

(1) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the medical malpractice litigation systems existing throughout the United States affect interstate commerce by contributing to the high cost of health care and premiums for malpractice insurance purchased by health care providers.

(2) EFFECT ON FEDERAL SPENDING.—Congress finds that the medical malpractice litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent by their employers to provide them with health insurance benefits;

(C) the large number of health care providers and health care professionals who provide items or services for which the Federal Government makes payments; and

(D) the large number of such providers and professionals who have received direct or indirect financial assistance from the Federal Government because of their status as such professionals or providers.

(b) APPLICABILITY.—This subtitle shall apply with respect to any medical malpractice liability claim and to any medical malpractice liability action brought in any State or Federal court, except that this subtitle shall not apply to—

(1) a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action; or

(2) a claim or action in which the plaintiff's sole allegation is an allegation of an injury arising from the use of a medical product.

(c) PREEMPTION OF STATE LAW.—Subject to section 331, this subtitle supersedes State law only to the extent that State law differs from any provision of law established by or under this subtitle. Any issue that is not governed by any provision of law established by or under this subtitle shall be governed by otherwise applicable State or Federal law.

(d) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of sections 1331 or 1337 of title 28, United States Code.

SEC. 312. DEFINITIONS.

As used in this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established by a State that provides for the resolution of medical malpractice liability claims in a manner other than through medical malpractice liability actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice liability claim, or, in the case of an individual who is de-

ceased, incompetent, or a minor, the person on whose behalf such a claim is alleged.

(3) ECONOMIC DAMAGES.—The term ''economic damages'' means damages paid to compensate an individual for losses for hospital and other medical expenses, lost wages, lost employment, and other pecuniary losses.

(4) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by State law or regulation to be licensed or certified by the State to provide such services in the State.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(6) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice liability action or claim.

(7) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability ac-

tion'' means a civil action (other than an action in which the plaintiff's sole allegation is an allegation of an intentional tort) brought in a State or Federal court against a health care provider or health care professional (regardless of the theory of liability on which the action is based) in which the plaintiff alleges a medical malpractice liability claim.

(8) MEDICAL MALPRACTICE LIABILITY CLAIM.—The term ''medical malpractice liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(9) MEDICAL PRODUCT.—The term ''medical product'' means a device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) or a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act).

(10) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to compensate an individual for losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary losses, but does not include punitive damages.

(11) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(12) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

SEC. 313. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b) and sections 330 and 351, this subtitle shall apply with respect to claims accruing or actions brought on or after the expiration of the 3-year period that begins on the date of the enactment of this Act.

(b) EXCEPTION FOR STATES REQUESTING EARLIER IMPLEMENTATION OF REFORMS.—

(1) APPLICATION.—A State may submit an application to the Secretary requesting the early implementation of this subtitle with respect to claims or actions brought in the State.

(2) DECISION BY SECRETARY.—The Secretary shall issue a response to a State's application under paragraph (1) not later than 90 days after receiving the application. If the Secretary determines that the State meets the requirements of this subtitle at the time of submitting its application, the Secretary shall approve the State's application, and this sub-

title shall apply with respect to actions brought in the State on or after the expiration of the 90-day period that begins on the date the Secretary issues the response. If the Secretary denies the State's application, the Secretary shall provide the State with a written explanation of the grounds for the decision.

PART 2—UNIFORM STANDARDS FOR MEDICAL MALPRACTICE LIABILITY

SEC. 321. STATUTE OF LIMITATIONS.

(a) IN GENERAL.—No medical malpractice liability claim may be brought after the expiration of the 2-year period that begins on the date the alleged injury that is the subject of the action should reasonably have been discovered, but in no event after the expiration of the 4-year period that begins on the date the alleged injury occurred.

(b) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, no medical malpractice liability claim may be brought after the expiration of the 2-year period that begins on the date the alleged injury that is the subject of the action should reasonably have been discovered, but in no event after the date on which the minor attains 10 years of age.

SEC. 322. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—No medical malpractice liability action may be brought in any State court unless the medical malpractice liability claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified by the Secretary under section 341(b).

(b) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of subsection (a), an action is ''initially resolved'' under an alternative dispute resolution system if—

(1) the ADR reaches a decision on whether the defendant is liable to the plaintiff for damages; and

(2) if the ADR determines that the defendant is liable, the ADR determines the amount of damages assessed against the defendant.

(c) PROCEDURES FOR FILING ACTIONS.—

(1) DEADLINE.—No medical malpractice liability action may be brought unless the action is filed in a court of competent jurisdiction not later than 90 days after an opinion resolving the medical malpractice liability claim that is the subject of the action is issued under the applicable alternative dispute resolution system.

(2) COURT OF COMPETENT JURISDICTION.—For purposes of paragraph (1), the term ''court of competent jurisdiction'' means—

(A) with respect to actions filed in a State court, the appropriate State trial court; and

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(d) STATUS OF ADR DECISION.—The decision reached under an alternative dispute resolution system shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of a medical malpractice liability action adjudicated in a State or Federal trial court.

(e) TREATMENT OF ADR DECISION.—

(1) REQUIREMENTS FOR GOING FORWARD WITH ACTION.—In order to bring a medical malpractice liability action to contest the decision made under the previous alternative dispute resolution system with respect to a medical malpractice liability claim, the party contesting the decision must—

(A) show that—

(i) the decision was procured by corruption, fraud, or undue means,

(ii) there was partiality or corruption under the system,

(iii) there was other misconduct under the system that materially prejudiced the party's rights, or

(iv) the decision was based on an error of law; or

(B) present new evidence before the trier of fact that was not available for presentation under the ADR system.

(2) BURDEN OF PROOF.—In any medical malpractice liability action, the trier of fact shall uphold the decision made under the previous alternative dispute resolution system with respect to the claim that is the subject of the action unless the party contesting the decision proves by a preponderance of the evidence that the decision was incorrect.

SEC. 323. RELATION TO ALTERNATIVE DISPUTE RESOLUTION OF FEDERAL AGENCIES.

(a) MANDATORY APPLICATION OF FEDERAL ADR IN MALPRACTICE CLAIMS AGAINST UNITED STATES.—Section 2672 of title 28, United States Code, is amended by striking the period at the end of the first paragraph and inserting the following: ‘‘, except that each Federal agency shall use arbitration or such alternative means of dispute

resolution to settle any tort claim against the United States consisting of a medical malpractice liability claim (as defined in section 312(8) of the Comprehensive Health and Rural Equality Act of 1993).''.

(b) TRANSMITTAL OF INFORMATION OF MALPRACTICE CLAIMS RESOLVED UNDER FEDERAL ADR.—Section 584 of title 5, United States Code, as added by section 4(b) of the Administrative Dispute Resolution Act (Public Law 101–552), is amended by adding at the end the following new subsection:

''(k) Each agency shall transmit on a regular basis to the Administrator for Health Care Policy and Research information on issues in controversy consisting of medical malpractice liability claims (as defined in section 312(8) of the Comprehensive Health and Rural Equality Act of 1993) that are resolved under the agency's dispute resolution proceeding under this subchapter, in a manner that assures that the identity of the parties to such proceedings shall not be revealed.''.

SEC. 324. MANDATORY PRETRIAL SETTLEMENT CONFERENCE.

(a) IN GENERAL.—Before the beginning of the trial phase of any medical malpractice liability action, the parties shall attend a conference called by the court for pur-

poses of determining whether grounds exist upon which the parties may negotiate a settlement for the action.

(b) REQUIRING PARTIES TO SUBMIT SETTLEMENT OFFERS.—At the conference called pursuant to subsection (a), each party to a medical malpractice liability action shall present an offer of settlement for the action.

SEC. 325. CALCULATION AND PAYMENT OF DAMAGES.

(a) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a plaintiff and the members of the plaintiff's family for losses resulting from the injury which is the subject of a medical malpractice liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) LIMITATION ON AMOUNT.—The total amount of punitive damages that may be imposed under a medical malpractice liability action may not exceed twice the total of the damages awarded to the plaintiff and the members of the plaintiff's family.

(2) PAYMENTS TO STATE FOR MEDICAL QUALITY ASSURANCE ACTIVITIES.—

(A) IN GENERAL.—Any punitive damages imposed under a medical malpractice liability

action shall be paid to the State in which the action is brought.

(B) ACTIVITIES DESCRIBED.—A State shall use amount paid pursuant to subparagraph (A) to carry out activities to assure the safety and quality of health care services provided in the State, including (but not limited to)—

(i) licensing or certifying health care professionals and health care providers in the State;

(ii) operating alternative dispute resolution systems;

(iii) carrying out public education programs relating to medical malpractice and the availability of alternative dispute resolution systems in the State; and

(iv) carrying out programs to reduce malpractice-related costs for retired providers or other providers volunteering to provide services in medically underserved areas.

(C) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to subparagraph (A) to supplement and not to replace

amounts spent by the State for the activities described in subparagraph (B).

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—If more than $100,000 in damages for expenses to be incurred in the future is awarded to the plaintiff in a medical malpractice liability action, the defendant shall provide for payment for such damages on a periodic basis determined appropriate by the court (based upon projections of when such expenses are likely to be incurred), unless the court determines that it is not in the plaintiff's best interests to receive payments for such damages on such a periodic basis.

(d) MANDATORY OFFSETS FOR DAMAGES PAID BY A COLLATERAL SOURCE.—

(1) IN GENERAL.—The total amount of damages received by a plaintiff in a medical malpractice liability action shall be reduced (in accordance with paragraph (2)) by any other payment that has been or will be made to the individual to compensate the plaintiff for the injury that was the subject of the action, including payment under—

(A) Federal or State disability or sickness programs;

(B) Federal, State, or private health insurance programs;

(C) private disability insurance programs;

(D) employer wage continuation programs; and

(E) any other source of payment intended to compensate the plaintiff for such injury.

(2) AMOUNT OF REDUCTION.—The amount by which an award of damages to a plaintiff shall be reduced under paragraph (1) shall be—

(A) the total amount of any payments (other than such award) that have been made or that will be made to the plaintiff to compensate the plaintiff for the injury that was the subject of the action; minus

(B) the amount paid by the plaintiff (or by the spouse, parent, or legal guardian of the plaintiff) to secure the payments described in subparagraph (A).

SEC. 326. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) LIMITATION ON ATTORNEY'S FEES.—If the plaintiff in a medical malpractice liability action has entered into an agreement with the plaintiff's attorney to pay the attorney's fees on a contingency basis, the attorney's fees for the action may not exceed—

(1) 25 percent of the first $150,000 of any award or settlement paid to the plaintiff; or

(2) 15 percent of any additional amounts paid to the plaintiff.

(b) AWARDING ATTORNEY'S FEES AND OTHER COSTS TO WINNING PARTY.—

(1) IN GENERAL.—If the court in a medical malpractice liability action upholds a ruling of the alternative dispute resolution system with respect to whether or not a health care professional or health care provider committed malpractice or with respect to the amount of damages awarded, the court shall require the party that contested the ruling to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim that is the subject of the action under the alternative dispute resolution system).

(2) PERMITTING COURT TO WAIVE OR MODIFY IMPOSITION OF COSTS.—A court may issue a written order waiving or modifying the application of paragraph (1) to a party if the court finds that the appli-

cation of such paragraph to the party would constitute an undue hardship, or if the medical malpractice liability action raised a novel issue of law. The order shall specify the grounds for the court's decision to waive or modify the application of such paragraph.

SEC. 327. JOINT AND SEVERAL LIABILITY.

The liability of each defendant in a medical malpractice liability action shall be several only and shall not be joint, and each defendant shall be liable only for the amount of damages allocated to the defendant in direct proportion to the defendant's percentage of responsibility (as determined by the trier of fact).

SEC. 328. UNIFORM STANDARD FOR DETERMINING NEGLIGENCE.

A defendant in a medical malpractice liability action may not be found to have acted negligently unless the defendant's conduct at the time of providing the health care services that are the subject of the action was not reasonable.

SEC. 329. APPLICATION OF MEDICAL PRACTICE GUIDELINES IN MALPRACTICE LIABILITY ACTIONS.

(a) USE OF GUIDELINES AS AFFIRMATIVE DEFENSE.—In any medical malpractice liability action, it shall be a complete defense to any allegation that the de-

fendant was negligent that, in the provision of (or the failure to provide) the services that are the subject of the action, the defendant followed the appropriate practice guideline.

(b) RESTRICTION ON GUIDELINES CONSIDERED APPROPRIATE.—

(1) GUIDELINES SANCTIONED BY SECRETARY.—For purposes of subsection (a), a practice guideline may not be considered appropriate with respect to actions brought during a year unless the Secretary has sanctioned the use of the guideline for purposes of an affirmative defense to medical malpractice liability actions brought during the year in accordance with paragraph (2) or (3).

(2) ANNUAL PROCESS FOR SANCTIONING GUIDELINES.—By not later than October 1 of each year (beginning with 1994), the Secretary shall review the practice guidelines and standards developed by the Administrator for Health Care Policy and Research pursuant to section 1142 of the Social Security Act, and shall sanction those guidelines which the Secretary considers appropriate for purposes of an affirmative defense to medical malpractice liability actions brought during the next year as appro-

priate practice guidelines for purposes of subsection (a).

(3) USE OF STATE GUIDELINES.—Upon the application of a State, the Secretary may sanction practice guidelines selected by the State for purposes of an affirmative defense to medical malpractice liability actions brought in the State as appropriate practice guidelines for purposes of subsection (a) if the guidelines meet such requirements as the Secretary may impose.

(c) PROHIBITING APPLICATION OF FAILURE TO FOLLOW GUIDELINES AS PRIMA FACIE EVIDENCE OF NEGLIGENCE.—No plaintiff in a medical malpractice liability action may be deemed to have presented prima facie evidence that a defendant was negligent solely by showing that the defendant failed to follow the appropriate practice guideline.

(d) PROMOTION OF MEDICAL PRACTICE GUIDELINES.—

(1) CONSIDERATION OF MALPRACTICE LIABILITY DATA IN DEVELOPING AND UPDATING GUIDELINES.—Section 1142(c)(5) of the Social Security Act (42 U.S.C. 1320b–12(c)(5)) is amended by striking ''claims data'' and all that follows through ''patients'' and inserting the following: ''claims data,

data on clinical and functional status of patients, and data on medical malpractice liability actions''.

(2) DEVELOPMENT OF REPORTING FORMS FOR STATE ADR SYSTEMS.—The Secretary, in consultation with the Administrator for the Health Care Policy and Research, shall develop a standard reporting form to be used by State alternative dispute resolution systems in transmitting information to the Administrator pursuant to section 341(a)(7) of this Act on disputes resolved under such systems.

(e) FUNDING ESTABLISHMENT OF PRACTICE GUIDELINES.—

(1) IN GENERAL.—Each insurer or other entity that provides individual or group health coverage (as defined by the Secretary), including health insurance and coverage under an employer group health plan, shall pay to the Secretary, at a time and in a manner specified by the Secretary, ¼ of 1 percent of the gross premiums or other amounts paid for the provision of such coverage.

(2) PLACEMENT IN A SEPARATE ACCOUNT.—Amounts paid to the Secretary under paragraph (1) shall be placed in a separate account in the Treasury.

(3) USE OF FUNDS FOR PRACTICE GUIDELINES.—Amounts in such account shall only be available, pursuant to appropriations Act, for purposes of establishing and sanctioning practice guidelines to carry out this section.

(4) SUPPLEMENTATION.—The funds in such account are intended to supplement, and not to displace, amounts otherwise appropriated for the establishment of such practice guidelines.

SEC. 330. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IMPOSITION OF HIGHER STANDARD OF PROOF.—

(1) IN GENERAL.—In the case of a medical malpractice liability action relating to services provided during labor or the delivery of a baby, if the defendant health care professional did not previously treat the plaintiff for the pregnancy, the trier of fact may not find that the defendant committed malpractice and may not assess damages against the defendant unless the malpractice is proven by clear and convincing evidence.

(2) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of paragraph (1), a health care professional shall be considered to have previously treated an individual

for a pregnancy if the professional is a member of a group practice whose members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another professional.

(b) CLEAR AND CONVINCING EVIDENCE DEFINED.—In subsection (a), the term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

(c) EFFECTIVE DATE.—This section shall apply to claims accruing or actions brought on or after the expiration of the 2-year period that begins on the date of the enactment of this Act.

SEC. 331. PREEMPTION.

(a) IN GENERAL.—This part supersedes any State law only to the extent that State law—

(1) permits the recovery of a greater amount of damages by a plaintiff;

(2) permits the collection of a greater amount of attorneys' fees by a plaintiff's attorney;

(3) establishes a longer period during which a medical malpractice liability claim may be initiated; or

(4) establishes a stricter standard for determining whether a defendant was negligent or for determining the liability of defendants described in section 330(a) in actions described in such section.

(b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (a) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen

of a foreign nation on the ground of inconvenient forum.

PART 3—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS

SEC. 341. BASIC REQUIREMENTS FOR ADR.

(a) IN GENERAL.—A State's alternative dispute resolution system meets the requirements of this section if the system—

(1) applies to all medical malpractice liability claims under the jurisdiction of the State courts;

(2) requires that a written opinion resolving the dispute be issued that contains findings of fact relating to the dispute;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications as the State may require (in accordance with regulations of the Secretary);

(4) is approved by the State or by local governments in the State;

(5) with respect to a State system that consists of multiple dispute resolution procedures—

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system, and

(B) if the parties do not agree on the procedure to be used for the resolution of the dispute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings a medical malpractice liability action contesting the decision made under the system; and

(7) provides for the regular transmittal to the Administrator for Health Care Policy and Research of information on disputes resolved under the system, in a manner that assures that the identity of the parties to a dispute shall not be revealed.

(b) APPLICATION OF MALPRACTICE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of part 2 shall apply with respect to claims brought under a State's alternative dispute resolution system in the same manner as such provisions apply with

respect to medical malpractice liability actions brought in the State.

SEC. 342. CERTIFICATION OF STATE SYSTEMS.

(a) IN GENERAL.—Not later than October 1 of each year (beginning with 1994), the Secretary, in consultation with the Attorney General, shall determine whether a State's alternative dispute resolution system meets the requirements of this part for the following calendar year.

(b) BASIS FOR CERTIFICATION.—The Secretary shall certify a State's alternative dispute resolution system under this subsection if the Secretary determines under subsection (a) that the system meets the requirements of section 341.

SEC. 343. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this part.

(b) CONTENTS OF REPORT.—The Secretary shall include in the report prepared and submitted under subsection (a)—

(1) information on—

(A) the effect of such systems on the cost of health care within the State,

(B) the impact of such systems on the access of individuals to health care within the State, and

(C) the effect of such systems on the quality of health care provided within such State; and

(2) to the extent that such report does not provide information on no-fault systems operated by States as alternative dispute resolution systems pursuant to this part, an analysis of the feasibility and desirability of establishing a system under which medical malpractice liability claims shall be resolved on a no-fault basis.

PART 4—OTHER REQUIREMENTS AND PROGRAMS

SEC. 351. PERMITTING STATE PROFESSIONAL SOCIETIES TO PARTICIPATE IN DISCIPLINARY ACTIVITIES.

(a) ROLE OF PROFESSIONAL SOCIETIES.—Notwithstanding any other provision of State or Federal law, a State agency responsible for the conduct of disciplinary actions for a type of health care practitioner may enter into agreements with State or county professional societies

of such type of health care practitioner to permit such societies to participate in the licensing of such health care practitioner, and to review any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of any such health care practitioner. Any such agreement shall comply with subsection (b).

(b) REQUIREMENTS OF AGREEMENTS.—Any agreement entered into under subsection (a) for licensing activities or the review of any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of a health care practitioner shall provide that—

(1) the health care professional society conducts such activities or review as expeditiously as possible;

(2) after the completion of such review, such society shall report its findings to the State agency with which it entered into such agreement;

(3) the conduct of such activities or review and the reporting of such findings be conducted in a manner which assures the preservation of confidentiality of health care information and of the review process; and

(4) no individual affiliated with such society is liable for any damages or injury directly caused by

the individual's actions in conducting such activities or review.

(c) AGREEMENTS NOT MANDATORY.—Nothing in this section may be construed to require a State to enter into agreements with societies described in subsection (a) to conduct the activities described in such subsection.

(d) EFFECTIVE DATE.—This section shall take effect 2 years after the date of the enactment of this Act.

Subtitle C—Administrative Cost Savings

PART 1—STANDARDIZED CLAIMS PROCESSING

SEC. 361. ADOPTION OF DATA ELEMENTS, UNIFORM CLAIMS, AND UNIFORM ELECTRONIC TRANSMISSION STANDARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall adopt standards relating to each of the following:

(1) Data elements for use in paper and electronic claims processing under health benefit plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

(2) Uniform claims forms (including uniform procedure and billing codes for uses with such forms and including information on other health benefit plans that may be liable for benefits).

(3) Uniform electronic transmission of the data elements (for purposes of billing and utilization review).

Standards under paragraph (3) relating to electronic transmission of data elements for claims for services shall supersede (to the extent specified in such standards) the standards adopted under paragraph (2) relating to the submission of paper claims for such services. Standards under paragraph (3) shall include protections to assure the confidentiality of patient-specific information and to protect against the unauthorized use and disclosure of information.

(b) USE OF TASK FORCES.—In adopting standards under this section—

(1) the Secretary shall take into account the recommendations of current task forces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute;

(2) the Secretary shall consult with the National Association of Insurance Commissioners (and, with respect to standards under subsection (a)(3), the American National Standards Institute); and

(3) the Secretary shall, to the maximum extent practicable, seek to make the standards consistent with any uniform clinical data sets which have been adopted and are widely recognized.

(c) DEADLINES FOR PROMULGATION.—The Secretary shall promulgate the standards under—

(1) subsection (a)(1) relating to claims processing data, by not later than 12 months after the date of the enactment of this Act;

(2) subsection (a)(2) (relating to uniform claims forms) by not later than 12 months after the date of the enactment of this Act; and

(3)(A) subsection (a)(3) relating to transmission of information concerning hospital and physicians services, by not later than 24 months after the date of the enactment of this Act, and

(B) subsection (a)(3) relating to transmission of information on other services, by such later date as the Secretary may determine it to be feasible.

(d) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary

shall report to Congress recommendations regarding restructuring the medicare peer review quality assurance program given the availability of hospital data in electronic form.

SEC. 362. APPLICATION OF STANDARDS.

(a) IN GENERAL.—If the Secretary determines, at the end of the 2-year period beginning on the date that standards are adopted under section 361 with respect to classes of services, that a significant number of claims for benefits for such services under health benefit plans are not being submitted in accordance with such standards, the Secretary may require, after notice in the Federal Register of not less than 6 months, that all providers of such services must submit claims to health benefit plans in accordance with such standards. The Secretary may waive the application of such a requirement in such cases as the Secretary finds that the imposition of the requirement would not be economically practicable.

(b) SIGNIFICANT NUMBER.—The Secretary shall make an affirmative determination described in subsection (a) for a class of services only if the Secretary finds that there would be a significant, measurable additional gain in efficiencies in the health care system that would be obtained by imposing the requirement described in such paragraph with respect to such services.

(c) APPLICATION OF REQUIREMENT.—

(1) IN GENERAL.—If the Secretary imposes the requirement under subsection (a)—

(A) in the case of a requirement that imposes the standards relating to electronic transmission of claims for a class of services, each health care provider that furnishes such services for which benefits are payable under a health benefit plan shall transmit electronically and directly to the plan on behalf of the beneficiary involved a claim for such services in accordance with such standards;

(B) any health benefit plan may reject any claim subject to the standards adopted under section 361 but which is not submitted in accordance with such standards;

(C) it is unlawful for a health benefit plan (i) to reject any such claim on the basis of the form in which it is submitted if it is submitted in accordance with such standards or (ii) to require, for the purpose of utilization review or as a condition of providing benefits under the plan, a provider to transmit medical data elements that are inconsistent with the standards established under section 361(a)(1); and

(D) the Secretary may impose a civil money penalty on any provider that knowingly and repeatedly submits claims in violation of such standards or on any health benefit plan (other than a health benefit plan described in paragraph (2)) that knowingly and repeatedly rejects claims in violation of subparagraph (B), in an amount not to exceed $100 for each such claim.

The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraph (D) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan—

(A) that is subject to regulation by a State, and

(B) with respect to which the Secretary finds that—

(i) the State provides for application of the standards established under section 361, and

(ii) the State regulatory program provides for the appropriate and effective enforcement of such standards.

(d) TREATMENT OF REJECTIONS.—If a plan rejects a claim pursuant to subsection (c)(1), the plan shall permit the person submitting the claim a reasonable opportunity to resubmit the claim on a form or in an electronic manner that meets the requirements for acceptance of the claim under such subsection.

SEC. 363. PERIODIC REVIEW AND REVISION OF STANDARDS.

(a) IN GENERAL.—The Secretary shall—

(1) provide for the ongoing receipt and review of comments and suggestions for changes in the standards adopted and promulgated under section 361;

(2) establish a schedule for the periodic review of such standards; and

(3) based upon such comments, suggestions, and review, revise such standards and promulgate such revisions.

(b) APPLICATION OF REVISED STANDARDS.—If the Secretary under subsection (a) revises the standards described in 501, then, in the case of any claim for benefits submitted under a health benefit plan more than the mini-

mum period (of not less than 6 months specified by the Secretary) after the date the revision is promulgated under subsection (a)(3), such standards shall apply under section 362 instead of the standards previously promulgated.

SEC. 364. HEALTH BENEFIT PLAN DEFINED.

In this subtitle, the term ''health benefit plan'' has the meaning given such term in section 208(2) and includes—

(1) the medicare program (under title XVIII of the Social Security Act) and medicare supplemental health insurance, and

(2) a State medicaid plan (approved under title XIX of such Act).

PART 2—ELECTRONIC MEDICAL DATA STANDARDS

SEC. 371. MEDICAL DATA STANDARDS FOR HOSPITALS AND OTHER PROVIDERS.

(a) PROMULGATION OF HOSPITAL DATA STANDARDS.—

(1) IN GENERAL.—Between July 1, 1995, and January 1, 1996, the Secretary shall promulgate standards described in subsection (b) for hospitals concerning electronic medical data.

(2) REVISION.—The Secretary may from time to time revise the standards promulgated under this subsection.

(b) CONTENTS OF DATA STANDARDS.—The standards promulgated under subsection (a) shall include at least the following:

(1) A definition of a standard set of data elements for use by utilization and quality control peer review organizations.

(2) A definition of the set of comprehensive data elements, which set shall include for hospitals the standard set of data elements defined under paragraph (1).

(3) Standards for an electronic patient care information system with data obtained at the point of care, including standards to protect against the unauthorized use and disclosure of information.

(4) A specification of, and manner of presentation of, the individual data elements of the sets and system under this subsection.

(5) Standards concerning the transmission of electronic medical data.

(6) Standards relating to confidentiality of patient-specific information.

The standards under this section shall be consistent with standards for data elements established under section 361.

(c) OPTIONAL DATA STANDARDS FOR OTHER PROVIDERS.—

(1) IN GENERAL.—The Secretary may promulgate standards described in paragraph (2) concerning electronic medical data for providers that are not hospitals. The Secretary may from time to time revise the standards promulgated under this subsection.

(2) CONTENTS OF DATA STANDARDS.—The standards promulgated under paragraph (1) for non-hospital providers may include standards comparable to the standards described in paragraphs (2), (4), and (5) of subsection (b) for hospitals.

(d) CONSULTATION.—In promulgating and revising standards under this section, the Secretary shall—

(1) consult with the American National Standards Institute, hospitals, with the advisory commission established under section 375, and with other affected providers, health benefit plans, and other interested parties, and

(2) take into consideration, in developing standards under subsection (b)(1), the data set used by the utilization and quality control peer review pro-

gram under part B of title XI of the Social Security Act.

SEC. 372. APPLICATION OF ELECTRONIC DATA STANDARDS TO CERTAIN HOSPITALS.

(a) MEDICARE REQUIREMENT FOR SHARING OF HOSPITAL INFORMATION.—As of January 1, 1997, subject to paragraph (2), each hospital, as a requirement of each participation agreement under section 1866 of the Social Security Act, shall—

(1) maintain clinical data included in the set of comprehensive data elements under section 371(b)(2) in electronic form on all inpatients,

(2) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI of such Act), transmit electronically the data set, and

(3) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set, in accordance with the standards promulgated under section 371(a).

(b) WAIVER AUTHORITY.—Until January 1, 2000:

(1) The Secretary may waive the application of the requirements of subsection (a) for a hospital

that is a small rural hospital, for such period as the hospital demonstrates compliance with such requirements would constitute an undue financial hardship.

(2) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is in the process of developing a system to provide the required data set and executes agreements with its fiscal intermediary and its utilization and quality control peer review organization that the hospital will meet the requirements of subsection (a) by a specified date (not later than January 1, 2000).

(3) The Secretary may waive the application of the requirement of subsection (a)(1) for a hospital that agrees to obtain from its records the data elements that are needed to meet the requirements of paragraphs (2) and (3) of subsection (a) and agrees to subject its data transfer process to a quality assurance program specified by the Secretary.

(c) APPLICATION TO HOSPITALS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall provide that each hospital of the Department of Veterans Affairs shall comply with the requirements of subsection (a) in the same manner

as such requirements would apply to the hospital if it were participating in the medicare program.

(2) WAIVER.—Such Secretary may waive the application of such requirements to a hospital in the same manner as the Secretary of Health and Human Services may waive under subsection (b) the application of the requirements of subsection (a).

SEC. 373. ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.

(a) IN GENERAL.—Effective January 1, 2000, if a provider is required under a Federal program to transmit a data element that is subject to a presentation or transmission standard (as defined in subsection (b)), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider to present and transmit the data element electronically in accordance with such a standard.

(b) PRESENTATION OR TRANSMISSION STANDARD DEFINED.—In subsection (a), the term ''presentation or transmission standard'' means a standard, promulgated under subsection (b) or (c) of section 371, described in paragraph (4) or (5) of section 371(b).

SEC. 374. LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS ARE IN EFFECT.

(a) IN GENERAL.—If standards with respect to data elements are promulgated under section 371 with respect to a class of provider, a health benefit plan may not require, for the purpose of utilization review or as a condition of providing benefits under the plan, that a provider in the class—

(1) provide any data element not in the set of comprehensive data elements specified under such standards, or

(2) transmit or present any such data element in a manner inconsistent with the applicable standards for such transmission or presentation.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

SEC. 375. ADVISORY COMMISSION.

(a) IN GENERAL.—The Secretary shall establish an advisory commission including hospital executives, hospital data base managers, physicians, health services researchers, and technical experts in collection and use of data and operation of data systems. Such commission shall include, as ex officio members, a representative of the Director of the National Institutes of Health, the Administrator for Health Care Policy and Research, the Secretary of Veterans Affairs, and the Director of the Centers for Disease Control.

(b) FUNCTIONS.—The advisory commission shall monitor and advise the Secretary concerning—

(1) the standards established under this part, and

(2) operational concerns about the implementation of such standards under this part.

(c) STAFF.—From the amounts appropriated under subsection (d), the Secretary shall provide sufficient staff to assist the advisory commission in its activities under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

PART 3—ADDITIONAL STANDARDS AND REQUIREMENTS

SEC. 381. STANDARDS RELATING TO USE OF MEDICARE AND MEDICAID MAGNETIZED HEALTH BENEFIT CARDS; SECONDARY PAYOR DATA BANK.

(a) MAGNETIZED IDENTIFICATION CARDS UNDER MEDICARE PROGRAM.—The Secretary shall adopt standards relating to the design and use of magnetized medicare identification cards in order to assist health care providers providing medicare covered services to individuals—

(1) in determining whether individuals are eligible for benefits under the medicare program, and

(2) in billing the medicare program for such services provided to eligible individuals.

Such cards shall be designed to be compatible with machines currently employed to transmit information on

credit cards. Such cards also shall be designed to be able to be used with respect to the provision of benefits under medicare supplemental policies.

(b) ADOPTION UNDER MEDICAID PLANS.—

(1) IN GENERAL.—The Secretary shall take such steps as may be necessary to encourage and assist States to design and use magnetized medicaid identification cards that meet such standards, for use under their medicaid plans.

(2) LIMITATION ON MMIS FUNDS.—In applying section 1903(a)(3) of the Social Security Act, the Secretary may determine that Federal financial participation is not available under that section to a State which has provided for a magnetized card system that is inconsistent with the standards adopted under subsection (a).

(c) MEDICARE AND MEDICAID SECONDARY PAYOR DATA BANK.—The Secretary shall establish a medicare and medicaid information system which is designed to provide information on those group health plans and other health benefit plans that are primary payors to the medicare program and medicaid program under section 1862(b) or section 1905(a)(25) of the Social Security Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in equal proportions

from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, a total of $25,000,000 to carry out subsections (a) and (c), including the issuance of magnetized cards to medicare beneficiaries.

SEC. 382. PREEMPTION OF STATE QUILL PEN LAWS.

(a) IN GENERAL.—Effective January 1, 1995, no effect shall be given to any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic, form.

(b) SECRETARIAL AUTHORITY.—The Secretary of Health and Human Services may issue regulations to carry out subsection (a). Such regulations may provide for such exceptions to subsection (a) as the Secretary determines to be necessary to prevent fraud and abuse, with respect to controlled substances, and in such other cases as the Secretary deems appropriate.

SEC. 383. USE OF STANDARD IDENTIFICATION NUMBERS.

(a) IN GENERAL.—Effective January 1, 1995, each health benefit plan shall—

(1) for each of its beneficiaries that has a social security account number, use that number as the personal identifier for claims processing and related purposes, and

(2) for each provider that has a unique identifier for purposes of title XVIII of the Social Security Act and that furnishes health care items or services to a beneficiary under the plan, use that identifier as the identifier of that provider for claims processing and related purposes.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with standards established under subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

SEC. 384. COORDINATION OF BENEFIT STANDARDS.

(a) REVIEW OF COORDINATION OF BENEFIT PROBLEMS.—Between July 1, 1995, and January 1, 1996, the Secretary shall determine whether problems relating to—

(1) the rules for determining the liability of health benefit plans when benefits are payable under two or more such plans, or

(2) the availability of information among such health benefit plans when benefits are so payable,

cause significant administrative costs.

(b) CONTINGENT PROMULGATION OF STANDARDS.—

(1) IN GENERAL.—If the Secretary determines that such problems do cause significant administrative costs that could be significantly reduced through the implementation of standards, the Secretary shall promulgate standards concerning—

(A) the liability of health benefit plans when benefits are payable under two or more such plans, and

(B) the transfer among health benefit plans of appropriate information (which may include standards for the use of unique identifi-

ers, and for the listing of all individuals covered under a health benefit plan) in determining liability in cases when benefits are payable under two or more such plans.

(2) EFFECTIVE DATE.—The standards promulgated under paragraph (1) shall become effective on a date specified by the Secretary, which date shall be not earlier than one year after the date of promulgation of the standards.

(c) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with standards promulgated under subsection (b) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a

health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the standards established under subsection (b), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such standards with respect to such plans.

(d) REVISION OF STANDARDS.—If the Secretary establishes standards under subsection (b), the Secretary may revise such standards from time to time and such revised standards shall be applied under subsection (c) on or after such date (not earlier than 6 months after the date the revision is promulgated) as the Secretary shall specify.

Subtitle C—Estimates of Expenses Prior to Treatment

SEC. 391. REQUIREMENT.

(a) IN GENERAL.—If requested, except as provided in subsection (b), each hospital, physician, or other provider of a health care item or service, before providing any health care item or services to any individual in the United States shall disclose to the individual (in form and manner specified by the Secretary of Health and Human Services) a range of prices to be charged for the item or service.

In the case of provision of items and services for which the particular services to be provided are not readily determinable in advance, the Secretary shall permit the use of such estimates as may be appropriate.

(b) EXCEPTION FOR EMERGENCIES.—Subsection (a) shall not apply in the case of emergency treatment and such other extenuating circumstances as the Secretary may provide by regulation.

(c) ENFORCEMENT.—No individual shall be liable for payment for a health care item or service for which a disclosure is required under subsection (a), if the disclosure has not been substantially made in accordance with such subsection.

(d) EFFECTIVE DATE.—This section shall apply to items and services furnished on or after 1 year after the date of the enactment of this Act.

Subtitle D—Antitrust Exemptions

SEC. 395. PERMITTING COOPERATIVE ARRANGEMENTS BETWEEN HOSPITALS.

(a) EXEMPTION.—Upon issuance of a certificate under subsection (c) with respect to an arrangement, the antitrust laws shall not apply with respect to—

(1) an arrangement among hospitals providing for (or attempting to provide for) the combination of two or more hospitals, or

(2) a cooperative arrangement entered into solely by two or more hospitals with respect to sharing expensive capital-intensive medical technology or other highly resource-intensive services.

(b) APPLICATION.—In order to obtain the benefits of subsection (a) with respect to an arrangement, one or more licensed hospitals may submit to the Secretary of Health and Human Services an application, containing such information as the Secretary may require with respect to the arrangement, including—

(1) a statement that such hospital desires to negotiate and enter into a voluntary cooperative arrangement under which the hospital is operating in one State or region for the sharing of medical technology or services with another hospital;

(2) a description of the nature and scope of the activities contemplated under the arrangement that demonstrates that consumer costs would not increase under the arrangement;

(3) a description of the financial arrangement between the hospital and other hospitals that are parties to the arrangement; and

(4) any other information determined appropriate by the Secretary.

(c) EVALUATIONS OF APPLICATIONS.—Not later than 120 days after the date an application under subsection (b) is received, the Secretary, in consultation with the Administrator for the Health Care Financing Administration, shall issue a certificate approving the arrangement if the Secretary determines that under the arrangement—

(1) Federal expenditures will be reduced;

(2) hospital services in geographical proximity to the communities traditionally served will be preserved; and

(3) consumer costs would not increase.

(d) ANTITRUST LAWS DEFINED.—For purposes of this section, the term ''antitrust laws'' has the meaning given such term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies with respect to unfair methods of competition.

TITLE IV—LONG-TERM CARE

Subtitle A—Treatment of Long-Term Care Insurance Plans

SEC. 401. QUALIFIED LONG-TERM CARE INSURANCE TREATED AS ACCIDENT AND HEALTH INSURANCE FOR PURPOSES OF TAXATION OF LIFE INSURANCE COMPANIES.

(a) IN GENERAL.—Section 818 of the Internal Revenue Code of 1986 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED LONG-TERM CARE INSURANCE TREATED AS ACCIDENT OR HEALTH INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to accident or health insurance shall be treated as including a reference to qualified long-term care insurance.

''(2) QUALIFIED LONG-TERM CARE INSURANCE.—For purposes of this subsection—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the term 'qualified long-term care insurance' means insurance under a policy or rider, which is issued by a qualified issuer, which meets standards at least as stringent as those set forth in the January 1990

Long-Term Care Insurance Model Regulation of the National Association of Insurance Commissioners, and which is certified by the Secretary of Health and Human Services (in accordance with procedures similar to the procedures prescribed in section 1882 of the Social Security Act (42 U.S.C. 1385ss) used in the certification of medicare supplemental policies (as defined in subsection (g)(1) of such section)) to be advertised, marketed, offered, or designed to provide coverage—

''(i) for not less than 12 consecutive months for each covered person who has attained age 50,

''(ii) on an expense incurred, indemnity, or prepaid basis,

''(iii) for 1 or more medically necessary, diagnostic services, preventive services, therapeutic services, rehabilitation services, maintenance services, or personal care services, and

''(iv) provided in a setting other than an acute care unit of a hospital.

The requirement of clause (iv) shall be met only if at least 1 of the settings in which such coverage is provided is the patient's home.

''(B) COVERAGE SPECIFICALLY EXCLUDED.—Such term does not include any insurance under any policy or rider which is offered primarily to provide any combination of the following kinds of coverage:

''(i) Basic Medicare supplement coverage.

''(ii) Basic hospital-based acute care expense coverage.

''(iii) Basic medical-surgical expense coverage.

''(iv) Hospital confinement indemnity coverage.

''(v) Major medical expense coverage.

''(vi) Disability income protection coverage.

''(vii) Accident only coverage.

''(viii) Specified disease coverage.

''(ix) Specified accident coverage.

''(x) Limited benefit health coverage.

''(C) QUALIFIED ISSUER.—For purposes of subparagraph (A), the term 'qualified issuer' means any of the following:

''(i) Private insurance company.

''(ii) Fraternal benefit society.

''(iii) Nonprofit health corporation.

''(iv) Nonprofit hospital corporation.

''(v) Nonprofit medical service corporation.

''(vi) Prepaid health plan.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1993.

SEC. 402. QUALIFIED LONG-TERM CARE INSURANCE TREATED AS ACCIDENT AND HEALTH INSURANCE FOR PURPOSES OF EXCLUSION FOR BENEFITS RECEIVED UNDER SUCH INSURANCE AND FOR EMPLOYER CONTRIBUTIONS FOR SUCH INSURANCE.

(a) IN GENERAL.—Section 105 of the Internal Revenue Code of 1986 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

''(j) SPECIAL RULES RELATING TO QUALIFIED LONG-TERM CARE INSURANCE.—For purposes of section 104, this section, and section 106—

''(1) BENEFITS TREATED AS PAYABLE FOR SICKNESS, ETC.—Any benefit received through qualified long-term care insurance (as defined in section 818(g)) shall be treated as received for personal injuries or sickness.

''(2) EXPENSES FOR WHICH REIMBURSEMENT PROVIDED UNDER QUALIFIED LONG-TERM CARE INSURANCE TREATED AS INCURRED FOR MEDICAL CARE.—Expenses incurred by a taxpayer for which reimbursement is paid through qualified long-term care insurance (as so defined) shall be treated for purposes of subsection (b) as incurred for medical care (as defined in section 213(d)).

''(3) REFERENCES TO ACCIDENT AND HEALTH PLANS.—Any reference to an accident or health plan shall be treated as including a reference to a plan providing qualified long-term care insurance.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1993.

SEC. 403. EXCLUSION FROM GROSS INCOME FOR AMOUNTS WITHDRAWN FROM INDIVIDUAL RETIREMENT PLANS OR 401(k) PLANS FOR QUALIFIED LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 136 as section 137 and by inserting after section 135 the following new section:

"SEC. 136. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT ACCOUNTS AND SECTION 401(k) PLANS FOR QUALIFIED LONG-TERM CARE INSURANCE.

''(a) GENERAL RULE.—The amount includible in the gross income of an individual for the taxable year by reason of qualified distributions during such taxable year shall not exceed the excess of—

''(1) the amount which would (but for this section) be so includible by reason of such distributions, over

''(2) the aggregate premiums paid by such individual during such taxable year for any policy of qualified long-term care insurance (as defined in section 818(g)) for the benefit of such individual or the spouse of such individual.

''(b) QUALIFIED DISTRIBUTION.—For purposes of this section, the term 'qualified distribution' means any

distribution to an individual from an individual retirement account or a section 401(k) plan if such individual has attained age 59½ on or before the date of the distribution (and, in the case of a distribution used to pay premiums for the benefit of the spouse of such individual, such spouse has attained age 59½ on or before the date of the distribution).

''(c) DEFINITIONS.—For purposes of this section—

''(1) INDIVIDUAL RETIREMENT ACCOUNT.—The term 'individual retirement account' has the meaning given such term by section 408(a).

''(2) SECTION 401(k) PLAN.—The term 'section 401(k) plan' means any employer plan which meets the requirements of section 401(a) and which includes a qualified cash or deferred arrangement (as defined in section 401(k)).

''(d) SPECIAL RULES FOR SECTION 401(k) PLANS.—

''(1) WITHDRAWALS CANNOT EXCEED ELECTIVE CONTRIBUTIONS UNDER QUALIFIED CASH OR DEFERRED ARRANGEMENT.—This section shall not apply to any distribution from a section 401(k) plan to the extent the aggregate amount of such distributions for the use described in subsection (a) exceeds the aggregate employer contributions made pursuant to the employee's election under section 401(k)(2).

''(2) WITHDRAWALS NOT TO CAUSE DISQUALIFICATION.—A plan shall not be treated as failing to satisfy the requirements of section 401, and an arrangement shall not be treated as failing to be a qualified cash or deferred arrangement (as defined in section 401(k)(2)), merely because under the plan or arrangement distributions are permitted which are excludable from gross income by reason of this section.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 401(k) of such Code is amended by adding at the end the following new paragraph:

''(11) CROSS REFERENCE.—

"For provision permitting tax-free withdrawals for payment of long-term care premiums, see section 136."

(2) Section 408(d) of such Code is amended by adding at the end the following new paragraph:

''(8) CROSS REFERENCE.—

For provision permitting tax-free withdrawals from individual retirement accounts for payment of long-term care premiums, see section 136."

(3) The table of sections for such part III is amended by striking the last item and inserting the following new items:

''Sec. 136. Distributions from individual retirement accounts and section 401(k) plans for qualified long-term care insurance.

''Sec. 137. Cross references to other Acts.''

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1993.

SEC. 404. EXCHANGE OF LIFE INSURANCE POLICY FOR QUALIFIED LONG-TERM CARE POLICY NOT TAXABLE.

(a) IN GENERAL.—Subsection (a) of section 1035 of the Internal Revenue Code of 1986 (relating to certain exchanges of insurance policies) is amended by striking the period at the end of paragraph (3) and inserting ''; or'' and by adding at the end the following new paragraph:

''(4) in the case of an individual who has attained age 59½, a contract of life insurance or a contract of endowment insurance or an annuity contract for a contract of qualified long-term care insurance (as defined in section 818(g)) for the benefit of such individual or the spouse of such individual if such spouse has attained age 59½ on or before the date of the exchange.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1993.

Subtitle B—Treatment of Accelerated Death Benefits

SEC. 411. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) GENERAL RULE.—Section 101 of the Internal Revenue Code of 1986 (relating to certain death benefits) is amended by adding at the end thereof the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount paid to an individual under a life insurance contract on the life of an insured who is a terminally ill individual or who is permanently confined to a nursing home shall be treated as an amount paid by reason of the death of such insured.

''(2) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who has been certified by a physician, licensed under State law, as having an illness or physical condition which can reasonably be expected to result in death in 12 months or less.

''(3) PERMANENTLY CONFINED TO A NURSING HOME.—For purposes of this subsection, an individual has been permanently confined to a nursing

home if the individual is presently confined to a nursing home and has been certified by a physician, licensed under State law, as having an illness or physical condition which can reasonably be expected to result in the individual remaining in a nursing home for the rest of his life.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1993.

SEC. 412. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 of the Internal Revenue Code of 1986 (relating to other definitions and special rules) is amended by adding at the end thereof the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider or addendum on, or other provision of, a life insurance contract which provides for payments to an individual on the life of an insured upon such insured becoming a terminally ill individual (as defined in section 101(g)(2)) or being permanently confined to a nursing home (as defined in section 101(g)(3)).''

(b) DEFINITIONS OF LIFE INSURANCE AND MODIFIED ENDOWMENT CONTRACTS.—

(1) RIDER TREATED AS QUALIFIED ADDITIONAL BENEFIT.—Paragraph (5)(A) of section 7702(f) of such Code is amended by striking ''or'' at the end of clause (iv), by redesignating clause (v) as clause (vi), and by inserting after clause (iv) the following new clause:

''(v) any qualified accelerated death benefit rider (as defined in section 818(g)(2)) or any qualified long-term care insurance rider which reduces the death benefit, or''.

(2) TRANSITIONAL RULE.—For purposes of applying section 7702 or 7702A of the Internal Reve-

nue Code of 1986 to any contract (or determining whether either such section applies to such contract), the issuance of a rider or addendum on, or other provision of, a life insurance contract permitting the acceleration of death benefits (as described in section 101(g) of such Code) or for qualified long-term care insurance (as defined in section 849(b) of such Code) shall not be treated as a modification or material change of such contract.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning before, on, or after December 31, 1993.

TITLE V—INCENTIVES FOR PROVISION OF SERVICES IN RURAL AREAS

SEC. 501. DEDUCTION FOR MEDICAL SCHOOL EDUCATION LOAN INTEREST INCURRED BY DOCTORS SERVING IN MEDICALLY UNDERSERVED RURAL AREAS.

(a) IN GENERAL.—Paragraph (2) of section 163(h) of the Internal Revenue Code of 1986 (relating to disallowance of deduction for personal interest) is amended by striking ''and'' at the end of subparagraph (D), by redesignating subparagraph (E) as subparagraph (F), and

by inserting after subparagraph (D) the following new subparagraph:

''(E) any qualified medical education loan interest (within the meaning of paragraph (5)), and''.

(b) QUALIFIED MEDICAL EDUCATION LOAN INTEREST DEFINED.—Paragraph (5) of section 163(h) of such Code is amended to read as follows:

''(5) QUALIFIED MEDICAL EDUCATION LOAN INTEREST.—

''(A) IN GENERAL.—The term 'qualified medical education loan interest' means interest—

''(i) which is on a medical education loan of a physician,

''(ii) which is paid or accrued by such physician, and

''(iii) which accrues during the period—

''(I) such physician is providing primary care (including internal medicine, pediatrics, obstetrics/gynecology, family medicine, and osteopathy) to residents of a medically underserved rural area, and

''(II) such physician's principal place of abode is in such area.

''(B) MEDICAL EDUCATION LOAN.—The term 'medical education loan' means indebtedness incurred to pay the individual's—

''(i) qualified tuition and related expenses (as defined in section 117(b)) incurred for the medical education of such individual, or

''(ii) reasonable living expenses while away from home in order to attend an educational institution described in section 170(b)(1)(A)(ii) for the medical education of such individual.

''(C) PHYSICIAN.—For purposes of subparagraph (A), the term 'physician' has the meaning given such term by section 1861(r)(1) of the Social Security Act.

''(D) MEDICALLY UNDERSERVED RURAL AREA.—The term 'medically underserved rural area' means any rural area which is a medically underserved area (as defined in section 330(b) or 1302(7) of the Public Health Service Act).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 502. REQUIRING DEVELOPMENT OF COMPREHENSIVE PLANS FOR MEDICALLY UNDERSERVED RURAL POPULATIONS.

(a) STATE COMPREHENSIVE PLANS FOR MEDICALLY UNDERSERVED RURAL AREAS.—As a requirement of an agreement between the Secretary of Health and Human Services and a State under section 103(d)(2) in the case of a State that has one or more rural areas that are medically underserved areas (as defined in section 330(b) or 1302(7) of the Public Health Service Act), the State shall develop and submit to the Secretary a comprehensive plan that addresses the health care needs of the populations in all such areas. The comprehensive plan shall utilize, in the most efficient manner possible and to the maximum extent possible, the current resources of Federal, State, and local governments, including public health clinics.

(b) RESPONSE TO MANAGED COMPETITION.—

(1) IN GENERAL.—If a State is required to establish a comprehensive plan under subsection (a), the State may not operate a managed competition system (described in paragraph (2)) unless, with re-

spect to each medically underserved rural area in the State, either—

(A) the system provides assurances with respect to the timely and cost-effective delivery of appropriate health care in that area, or

(B) the application of the system is waived with respect to residents of such area and there is established, in accordance with the plan, an alternative method of assuring the timely and cost-effective delivery of appropriate health care in that area.

(2) MANAGED COMPETITION SYSTEM DESCRIBED.—A managed competition system described in this paragraph is a system under which a State assures access to basic health care services for all residents through the enrollment of such residents under a certified health plan offered by a health insurance purchasing cooperative or similar entity.

SEC. 503. INCLUSION OF TRANSPORTATION COSTS FOR PHYSICIANS IN UNDERSERVED RURAL AREAS IN THE PRACTICE INDEX UNDER THE MEDICARE PHYSICIAN PAYMENT SCHEDULE.

(a) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C. 1395w–4(e)) is amended—

(1) by adding at the end of paragraph (1) the following new subparagraph:

''(D) INCLUSION OF TRANSPORTATION COSTS.—In establishing the index under subparagraph (A)(i), the Secretary shall take into account transportation costs associated with providing health care services to patients in rural health professional shortage areas (as designated under section 332 of the Public Health Service Act).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 1994.

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HR 1976 IH——2

HR 1976 IH——3

HR 1976 IH——4

HR 1976 IH——5

HR 1976 IH——6

HR 1976 IH——7

HR 1976 IH——8

HR 1976 IH——9